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Disclosure Statement / Notice of Privacy Policies

Welcome! Washington State Law asks that all therapists provide clients with information about their qualifications, treatment approaches and service policies. This allows you to make a sound, informed choice when selecting a therapist.

Qualifications

I am a Washington State Licensed Mental Health Counselor. (License#LH00010863) I earned a Masters degree in Counseling Psychology in 2002 from Lewis and Clark Graduate School of Education in Portland, OR. My undergraduate work was also in Psychology at Whitman College. I completed a Certificate Program in Clinical Theory and Practice offered by Family Services. I also had the opportunity to work as an extern therapist for Samaritan Center of Puget Sound. Since graduating, I have worked on a crisis line in Portland (ProtoCall Services) and for two local community mental health agencies (Community Psychiatric Clinic and Navos Mental Health Solutions).

Treatment Philosophy

Therapy is a unique process and can often be challenging to describe. My first step will be to gather a history and understand the issues bringing you in. We will next work together to create treatment goals. I generally employ techniques from cognitive behavioral therapy and psychodynamic psychotherapy.

Benefits and Risks

People seek counseling to feel better. However, this does not generally happen right away. Therapy often brings up uncomfortable emotions like sadness, anxiety, guilt and anger. Therapy may also involve recalling painful memories. However, many find that addressing their challenges eventually leads to a reduced feeling of distress, improved relationships and resolution of specific problems. Therapy has been shown to have benefits but I can make no guarantees. Successful outcomes are also directly related to the work the client does out of session that only he/she controls.

Office Policies

Fee- My rate is \$110 for a 50 minute session. I do offer a \$15 discount (\$95 per session) for those who prefer to submit their own claims to their insurance company and pay full fee at time of session. I offer this discount due to the time and effort it saves me. I will, of course, provide all needed documentation to submit to your insurance company.

Cancellations - I have reserved this time for you. If you need to cancel your appointment for any reason, I will need at least 48 hours notice. Otherwise you, not your insurance company, will be charged the full fee of the session.

Court testimony - I do not provide oral or written opinions related to child custody, special reports or narratives for the court or court ordered treatment. In the event I'm subpoenaed by the court, I will charge my regular hourly fee for all written reports, testimony and travel/waiting time.

Confidentiality and Privacy Policies

As of April 2003, the Health Information Portability and Accountability Act of 1996 requires that I provide you with documentation about how I use and protect the information you provide me. The information provided below outlines your rights under the act and serves as your notice of my policies.

Information in your file - The record I keep includes the information I collect from you (phone number, insurance information, history, etc.) as well as the note I make after each of our sessions. The file may also contain information about any outside contacts that you authorize (such as to your doctor).

How your information is stored - I keep records secure on a password protected computer.

How or when your information will be used - Confidentiality is the cornerstone of therapy.

All information shared in session (including the fact that you are a client) is confidential. There are some situations (most of which are legally mandated) where some pieces of information are shared. To have trust in our therapeutic relationship, it is vital that you have a thorough understanding of when and to whom your information may be shared.

If you choose to use your health insurance, you should be aware that most companies require a diagnosis and in some cases addition information (such as a treatment plan) be submitted to process the claim. In rare cases the entire record is needed. I will, at your request, provide you with your record.

The **legally mandated exceptions to confidentiality** require me to contact outside sources to ensure your safety or the safety of others.

1. If the **client is in immediate danger of harming himself/herself**. Family members and the Designated Mental Health Professional for King County will be contacted in this event.
2. If the **client threatens or has plans to harm another individual** and there is the possibility of injury or death. In this event I would likely follow up with police and potential victims. (If I become aware that an individual is unknowing exposed to AIDS I will follow up with the local public health authority. Information will be released consistent with state rules.)
3. If the client reports that he/she is **abusing (including physical violence, sexual molestation and neglect) a minor child or vulnerable adult**, or if the client reports such acts by another, I must make a report to the appropriate agency and legal authorities.
4. If the client becomes involved in **legal action** where he/she places her own psychological condition before the court, the client forfeits his/her right to confidentiality.

Please be aware that I may be unavailable to assist with a crisis issue that arises between sessions.

If you are in crisis and need immediate assistance, please call the Crisis Clinic at 206-461-3222.

As part of providing the best possible services to you, I may seek consultation from other therapists from time to time. This is standard practice and does not breach confidentiality as no names or any other identifying information are used. The law also allows for a review of my records by other mental health professionals or public health agencies for audit or quality assurance.

Your rights under HIPAA

1. You have the right to a copy of your file and to amend any information you think is erroneous.
2. You have a right to an accounting of the disclosure of your information.
3. You have a right to a copy of this disclosure statement and notice of privacy policies and practices.
4. You have the right to file a complaint against me with the state department of health.

Upon reading and understanding these policies and the notice of privacy practices, please sign below.

I have read and understand this Disclosure Statement and Notice of Privacy Policies. Fee agreement and terms of confidentiality have been clearly explained to me. My signature below indicates that I agree to the terms and wish to enter treatment. I also understand that a copy of this form is available to me upon request.

Client Signature _____ Date _____

Therapist Signature _____ Date _____